UTAH-DOH-BES
FORM 79-R 9/02

MEDICAL REFUND REQUEST

24 39 233

1.Case Name:	7.List other medicaid recipients included on the case: Name ID Number
2.Address (refund should be mailed to:)	
3.Phone:	
4.Case Number:	
5.SS Number	
6.ID Number (only if included in the medical card)	

SECTION A - CAUSE OF THE ERROR: (mark box)

G Spenddown was computed incorrectly.
G Correct Spenddown collected; medical services less than spenddown paid.
G Spenddown based on anticipated income which was not realized.
G PCN Enrollment Fee

SECTION B - REFUND IDENTIFYING INFORMATION

1.Reason for Refund: _____

2.Volume References _____

3.Is client in a Nursing Home? Yes **G** No **G** Nursing home name: _____

4.Present status of case: Open **G** Closed **G**

SECTION C - ATTACHMENTS REQUIRED:

Spenddown

1. _____ Copy of payment record attached
2. _____ Copy of correct medical computation
3. _____ Written statement of refund request by client

PCN Enrollment Fee

1. _____ Copy of payment record attached
2. _____ Written refund request by client

SECTION D - MEDICAL REFUND CALCULATIONS

HEALTH DEPARTMENT ONLY

REFUND MONTH/YEAR	ACTUAL SPENDDOWN PAID (A)	CORRECTED SPENDDOWN PAID (B)	REFUND AMOUNT (A-B)
TOTAL THIS PAGE			
TOTAL BACK PAGE			
TOTAL ALL PAGES			

G **Check box if continued on back side**

SECTION E _____ _____
Local Office Team

_____
Worker's Signature Date

_____
Supervisor's Signature Date

SECTION F REFUND DISPOSITION

_____No Refund _____Refund of $_____

_____
Signature of Health Department Official Date

MEDICAL REFUND REQUEST CALCULATIONS

SECTION D - (continued)

REFUND MONTH/YEAR	ACTUAL SPENDDOWN PAID (A)	CORRECTED SPENDDOWN PAID (B)	REFUND AMOUNT (A-B)	HEALTH DEPARTMENT ONLY
TOTAL THIS PAGE				